

## NOTICE OF ASSESSMENT REPORT

Due February 28, 2006

**All health care service contractors, health maintenance organizations and disability carriers must complete this Annual Assessment Report.**

This report is necessary to determine each Washington State Health Insurance Pool (WSHIP) Member's share of financial participation in WSHIP as directed by RCW 48.41.090. Failure to complete the Assessment Report and return it by February 28, 2006 will be considered an untimely response to a request from the Office of the Washington State Insurance Commissioner and may result in disciplinary action.

### Instructions

- Certain categories of enrollment are not subject to WSHIP assessment. Please refer to RCW 48.41.030 and the definitions below for specific information on what must be reported.
- Members are responsible for understanding the regulations and for accurate enrollment reporting.
- Members are being asked to report on lines of business (Medicare Advantage Plans, Federal Employee Health Benefits, and TRICARE) not subject to the assessment calculation in order to ensure that these enrollees are not inadvertently included in the assessment calculation. These lines of business are denoted on the Notice of Assessment Report form with an asterisk (\*) and must be included if you are reporting numbers on plans that do not have an asterisk. Otherwise, you are not required to report this data.
- Please note that lives insured by your organization as a Stop Loss carrier are assessed at a rate of one enrollee in ten. Please report the total number of insured persons. WSHIP will calculate the 1/10 assessment rate.
- Each WSHIP Member has received this report. If your organization is responding on behalf of subsidiary organizations, please indicate this in your response.
- Please explain any extraordinary difference between current enrollment and enrollment reported in your last report response.
- Please indicate any changes to your organization's mailing address from your last report. Please indicate if the name or phone number of the organization contact person has changed.
- **If your organization has no enrollment data to report, a response is still required.** If this is the case, please complete the company information, check the box indicating the form does not apply to your organization, and return it with the Declaration section signed and dated.
- Please note enrollment data is required to be reported for the last day of each month in the year. Add the data in the January through December boxes and enter the result in the TOTAL box.

### Summary of Legal Definitions

MEMBER as per RCW 48.41.030(14) means the Washington State Health Care Authority as issuer of the state uniform medical plan and the following licensed under Title 48 RCW:

Any commercial insurer that provides disability insurance or stop loss insurance  
Any Health Care Service Contractor  
Any Health Maintenance Organization

MEMBER **does not include** any insurer, Health Care Service Contractor, or Health Maintenance Organization whose products are exclusively:

Short-term care  
Long-term care  
Dental  
Vision  
Accident  
Fixed indemnity  
Disability income contracts  
Limited benefit or credit insurance  
Supplemental liability coverage  
Workers' Compensation or similar coverage  
Automobile medical payment coverage  
Statutorily required benefits regardless of fault in a liability contract or self insured plan  
(See RCW 48.41.030(10))

~~HEALTH COVERAGE~~ as per RCW 48.41.030(10) means:

Any group or individual disability insurance policy  
Any health care service contract  
Any health maintenance agreement

Note: This category **includes** Medicare Supplement coverage as defined in RCW 48.66.020(1), stop-loss policies, individual health insurance policies, small and large group health plans, both the Washington State Healthy Options Medicaid program and our state Children's Health Insurance Program contracts, and coverage for two specific subsidy programs in Washington State -- The Basic Health Plan and Basic Health Plan Plus.

Health Coverage **does not include:**

Any insurance policy, health care service contract or health maintenance agreement entered into for the provision of health care services pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq.

Any civilian health and medical program for the uniform services (Tricare), 10 U.S.C 55 or the Federal Employee Health Benefits Program. Tricare does not include reporting for Tricare supplemental wrap-around plans.

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HEALTH PLAN as per RCW 48.41.030(11) means any arrangement by which persons, including dependents or spouses, covered or making application to be covered by the Washington State Health Insurance Pool, have access to hospital or medical benefits or reimbursement including:

Any group or individual disability insurance policy

Any health care service contract

Any health maintenance agreement

Uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not involving insurance or not governed by Title 48 RCW

Coverage under group contracts available only because of a connection with a particular organization or group.

Coverage by Medicare or other governmental benefits.

Health Plans do not include those types of programs excluded under the definition of health coverage in RCW 48.41.030(10).

**RETURN COMPLETED FORMS TO:** *Office of the Insurance Commissioner, Policy Division, Attn: WSHIP Assessment, PO Box 40258, Olympia, WA. 98504-0258. (Questions for the Office of the Insurance Commissioner can be directed to Michael Arnis at (360) 725-7043.)*

**NOTICE OF ASSESSMENT REPORT**  
**Washington State Health Insurance Pool**  
 (Ref. Regulatory Code of Washington Chapter 48.41)

Under Chapter 48.41 RCW, all Members of the Washington State Health Insurance Pool (WSHIP) are subject to assessment for WSHIP expenses. **Instructions:** This Report should be filed with the Office of Insurance Commissioner at the address below. It must be completed and returned by February 28, 2006. **STOP! PLEASE CHECK HERE IF YOU DO NOT HAVE ENROLLMENT IN ANY OF THE UNSTARRED CATEGORIES ON THIS FORM and complete the Company Information and Declaration sections only:** ☐

- **COMPANY INFORMATION**

<b>COMPANY NAME</b>	<b>NAIC #</b>
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**COMPANY ADDRESS**

<b>CONTACT NAME</b>	<b>CONTACT PHONE #</b>
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BILLING CONTACT		BILLING CONTACT PHONE #	

**BILLING ADDRESS (if different)**

• **2005 ENROLLMENT AFFIDAVIT – FOR HEALTH PLANS**

Please report Washington resident insured persons under your organization's health plans (as defined in RCW 48.41.030(11)) and Medicare Advantage, FEHBP and TRICARE, including spouse and dependents as of the last day of each month in 2005. (Don't report plans in the 12 categories listed at the top of Page Two.) **Please check here if your organization had no enrollment in any of the unstarred categories below and proceed to Page Five:** ☐

[illegible]

• **2005 ENROLLMENT AFFIDAVIT – FOR STOP LOSS COVERAGE (SELF-INSURED ENROLLMENT)**

Please report Washington resident insured persons, including spouses and dependents, who have coverage through a self-insured plan that has been reinsured by your organization's stop loss plan as of the last day of each month in 2005. **Please check this box if this does not apply to your organization:** ☐

		FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	Total

Use this space to explain any extraordinary differences in enrollment numbers on this form from your last report filed for 2004:

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Use this space to report any change in company mailing address or contact information from your last report filed for 2004:

**DECLARATION**

I hereby declare under penalty of perjury under the laws of the State of Washington that the enrollment information provided pursuant to this report is true and correct. I am authorized to execute this declaration on behalf of \_\_\_\_\_ (name of company) and certify that \_\_\_\_\_ (name of company) understands that this information will be used to calculate the assessment due and owing to the Washington State Health Insurance Pool as further explained in RCW 48.41.090.

Executed \_\_\_\_\_ (Date) At \_\_\_\_\_ (City & State)

By \_\_\_\_\_ (Signature of Officer) Title \_\_\_\_\_

Printed Name of Officer \_\_\_\_\_ Phone \_\_\_\_\_

Additional space if needed:

*FOR PREPARATION QUESTIONS CONTACT: Benefit Management, Inc. at 800-290-1368*

**RETURN COMPLETED FORM TO:** Office of the Washington State Insurance Commissioner, Policy Division, Attn: WSHIP Assessment, PO Box 40258, Olympia, WA 98504-0258. Street address for overnight mail: Insurance Building, Capitol Campus, 302 – 14<sup>th</sup> Ave SW, Olympia WA 98504

**Checklist: To be accepted, your form must be complete.**

- ☐ **All Company Information provided**
- ☐ **All applicable check boxes marked**
- ☐ **All applicable enrollment figures provided**
- ☐ **Declaration filled in and signed**

Questions for the Washington State Office of Insurance Commissioner can be directed to Michael Arnis at (360) 725-7043.

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